PART I

Section III

DD Consumer Intake and Screening Forms

For

Developmental Disability Services

PROVIDER MANUAL
FOR
COMMUNITY MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES
PROVIDERS
UNDER CONTRACT WITH
THE DIVISION OF MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES

DHR

JULY 2006

INTAKE
SCREENING SUMMARY

☐ Initial Family Supports Screening: Date ___/___/___
☐ Initial Intake and Evaluation Screening: Date ___/___/___

I. Consumer Information

Name:				
	First	*Middle*	*Last*	
Address:				
	Street/Apartment number if applicable			
	City	*County*	*State*	*Zip code*

Telephone			Gender ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ D ☐ W
Birthdate:		SSN#:		Medicaid #:
MHID#:		Primary Diagnosis:		
Supporting Documentation Included:	☐ Yes ☐ No	Secondary Diagnosis:		

Legal Status:	☐ Minor ☐ Competent ☐ Legally Incompetent (Documentation Required)		
Legal Guardian (if applicable)		Relationship to Consumer:	
Address:		Telephone #:	

Primary Contact for Correspondence:		Relationship to Consumer:	
Address:		Telephone:	
Next of Kin:		Relationship to Consumer:	
Address:		Telephone #:	

Sensory Impairments:	☐ No Sensory Impairment	☐ Visual Impairment
	☐ Hearing Impairment	☐ Both Vision and Hearing Impairment
English Proficiency:	☐ E = English Proficiency	☐ S = Limited/No English – primary language Spanish
	☐ O = Limited/No English–primary language Other:	☐ N = Non Applicable

II. Referred by:

☐ Support Coordinator	☐ Service Provider	☐ Regional Office	☐ Consumer/Family/Guardian
Contact Person:		Telephone #:	

III. Services currently receiving:

☐ GIA	☐ Family Supports	☐ Source	☐ CCSP	☐ Respite	☐ School	☐ Other

Comments:	

INTAKE
SCREENING SUMMARY

Immediate Need (person needs service immediately):

☐ Death of the caregiver with no other supports (i.e., other family) available

☐ Caregiver incapacitated with no other supports (i.e., other family) available (due to physical or psychological reasons).

☐ Caregiver unable or unwilling to continue providing care (Person dropped off; caregiver not found)

☐ Current placement poses an immediate danger to health and/or safety of the individual or others.

☐ Other family crisis with no caregiver support available. Specify:

☐ Person may not remain in current institutional placement due to JL-JR ruling.

☐ Individual is inappropriately placed in mental health facility and is in danger of being victimized by other residents.

Short Term Need (person needs services within 6 months)

Level 1 Priority Short Term Need (1 – 5)

☐ 1. There has been a death or other family crisis in the family, significantly jeopardizing the capacity of the caregiver to provide care

☐ 2. Caregiver is ill and will soon be unable to continue providing care

☐ 3. Person has behavioral issues posing potential serious harm to self or others or behavior is likely to come to the attention of law enforcement.

☐ 4. Individual's health or behavioral needs have increased and needs cannot be met by current caregivers. Without additional support health and/or safety are jeopardized.

☐ 5. Individual is in an inappropriate mental health institutional placement where habilitation needs can not be met.

Level 2 Priority Short Term Need (6 - 11)

☐ 6. Caregiver is ill and will soon be unable to continue to provide care.

☐ 7. Person has a caregiver(s) who would not be able to work if services are not provided.

☐ 8. Person is scheduled to leave jail, prison, DJJ or MHDDAD Forensic services in the next 6 months and does not have an adequate natural support system

☐ 9. Caregiver has diminished capacity to meet needs

☐ 10. Behavioral issues are moderate to severe but do not currently pose a danger to self or others.

☐ 11. Person is "aging out" of DFCS residential placement within 6 months and does not have an adequate support system.

Level 3 Priority Short Term Need (12 - 15)

☐ 12. Inappropriate placement, awaiting proper placement (can manage for a short term).

☐ 13. Person has an aging caregiver (age 60+) who will soon not be able to continue providing care.

☐ 14. Person has exited special education or will exit within next 6 months and needs day/employment services

☐ 15. Circumstances of person or caregiver demonstrate clear need for alternative living arrangements within 6 months. Specify:

Long Term need (person needs services 6 months or more in the future)

☐ Person is eligible, is not currently in need of services, but will need service if something happens to the caregiver

☐ Person known to need service 6 months or more in future. Specify:
Enter date (___/___/___)

☐ Person is "aging out" of DFCS residential placement 6 months or more in the future and does not have and adequate support system.
Enter date (___/___/__)

☐ Person is leaving jail, prison, or other criminal justice setting 6 months or more in the future and will need services when he/she returns to the community. Enter date (___/___/___)

IV. Findings

☐ Immediate Need Due to:	
☐ Short Term List – Level 1 Due to:	
☐ Short Term List – Level 2 Due to:	
☐ Short Term List – Level 3 Due to:	
☐ Long Term List Due to:	

V. Services Needed - Long Term

☐ Residential	☐ Day Program	☐ Supported Employment		☐ Personal Supports	
☐ Respite	☐ Day Hab	☐ NSE	☐ Self Directed NSE	☐ Family Supports	
☐ Other - Specify					

Services Needed – Short Term

☐ Residential	☐ Day Program	☐ Supported Employment		☐ Personal Supports	
☐ Respite	☐ Day Hab	☐ NSE	☐ Self Directed NSE	☐ Family Supports	☐ Other
☐ Other - Specify					

INTAKE
SCREENING SUMMARY

Eligibility:	☐ Eligible	☐ Not Eligible
Services:	☐ Services Needed	☐ Services Not Needed
More information Needed to determine eligibility	☐ Psychological ☐ Other	☐ Updated Medical Information

VI. Provided Information on:

State Resources
- ☐ Voc Rehab
- ☐ Division of Aging
- ☐ DFCS
- ☐ Family Support Provider
- ☐ CMS
- ☐ Who to contact for PL changes (Regional Office)

Advocacy Groups / Other Resources
- ☐ Unlock the Waiting List
- ☐ Family Connections
- ☐ Parent to Parent
- ☐ Emory Autism Center
- ☐ SOURCE

- ☐ Local Community contacts
- ☐ Respite Provider
- ☐ Division of Aging
- ☐ Support Coordination
- ☐ United Way
- ☐ Marcus Institute
- ☐ Other

VII. Recommendations

Signature of Staff Completing the Screening	Date of Screening

Regional I&E Signature	Date

Subsequent Planning List Screening

Date of Screening ___/___/___

Reason for Screening_____

(note: *Initial Screening Summary* should be used in initial intake screening)

I. Consumer Information

Name:				
	First	*Middle*	*Last*	
Address:				
	Street/Apartment number if applicable			
	City	*County*	*State*	*Zip code*
Telephone				Marital Status: ☐ S ☐ M ☐ D ☐ W

Legal Status:	☐ Minor ☐ Competent ☐ Legally Incompetent (Documentation Required)		
Legal Guardian (if applicable)		Relationship to Consumer:	
Address:		Telephone #:	
Primary Contact for Correspondence:		Relationship to Consumer:	
Address:		Telephone:	
Next of Kin:		Relationship to Consumer:	
Address:		Telephone #:	

II. Services currently receiving:

☐ GIA	☐ Family Supports	☐ Source	☐ CCSP	☐ Respite	☐ School	☐ Other
Comments:						

DOCUMENTATION OF NEED FOR SERVICES

Immediate Need (person needs service immediately):

☐ Death of the caregiver with no other supports (i.e., other family) available

☐ Caregiver incapacitated with no other supports (i.e., other family) available (due to physical or psychological reasons).

☐ Caregiver unable or unwilling to continue providing care (Person dropped off; caregiver not found)

☐ Current placement poses an immediate danger to health and/or safety of the individual or others.

☐ Other family crisis with no caregiver support available. Specify:

☐ Person may not remain in current institutional placement due to JL-JR ruling.

☐ Individual is inappropriately placed in mental health facility and is in danger of being victimized by other residents.

Short Term Need (person needs services within 6 months: Y/N

Subsequent Planning List Screening

Level 1 Priority Short Term Need (1 – 5)

☐ 1. There has been a death or other family crisis in the family, significantly jeopardizing the capacity of the caregiver to provide care

☐ 2. Caregiver is ill and will soon be unable to continue providing care

☐ 3. Person has behavioral issues posing potential serious harm to self or others or behavior is likely to come to the attention of law enforcement.

☐ 4. Individual's health or behavioral needs have increased and needs cannot be met by current caregivers. Without additional support health and/or safety are jeopardized.

☐ 5. Individual is in an inappropriate mental health institutional placement where habilitation needs can not be met.

Level 2 Priority Short Term Need (6 - 11)

☐ 6. Caregiver is ill and will soon be unable to continue to provide care.

☐ 7. Person has a caregiver(s) who would not be able to work if services are not provided.

☐ 8. Person is scheduled to leave jail, prison, DJJ or MHDDAD Forensic services in the next 6 months and does not have an adequate natural support system

☐ 9. Caregiver has diminished capacity to meet needs

☐ 10. Behavioral issues are moderate to severe but do not currently pose a danger to self or others.

☐ 11. Person is "aging out" of DFCS residential placement within 6 months and does not have an adequate support system.

Level 3 Priority Short Term Need (12 - 15)

☐ 12. Inappropriate placement, awaiting proper placement (can manage for a short term).

☐ 13. Person has an aging caregiver (age 60+) who will soon not be able to continue providing care.

☐ 14. Person has exited special education or will exit within next 6 months and needs day/employment services

☐ 15. Circumstances of person or caregiver demonstrate clear need for alternative living arrangements within 6 months. Specify:

Planning for Long Term need (person needs services 6 months or more in the future)

☐ Person is eligible, is not currently in need of services, but will need service if something happens to the caregiver

☐ Person known to need service 6 months or more in future. Specify:
Enter date (___/___/___)

☐ Person is "aging out" of DFCS residential placement 6 months or more in the future and does not have and adequate support system.

Subsequent Planning List Screening

Enter date (___/___/__)

☐ Person is leaving jail, prison, or other criminal justice setting 6 months or more in the future and will need services when he/she returns to the community. Enter date (___/___/___)

III. Findings

☐ Immediate Need Due to:	
☐ Short Term List – Level 1 Due to:	
☐ Short Term List – Level 2 Due to:	
☐ Short Term List – Level 3 Due to:	
☐ Long Term List Due to:	

IV. Services Needed - Long Term

☐ Residential	☐ Day Program	☐ Supported Employment		☐ Personal Supports	
☐ Respite	☐ Day Hab	☐ NSE	☐ Self Directed NSE	☐ Family Supports	
☐ Other - Specify					

V. Services Needed – Short Term

☐ Residential	☐ Day Program	☐ Supported Employment		☐ Personal Supports	
☐ Respite	☐ Day Hab	☐ NSE	☐ Self Directed NSE	☐ Family Supports	☐ Other
☐ Other - Specify					

Needs Changed Since Last Screening? Yes ☐ NO ☐

(if Yes, inform I&E)

VI. Provided Information on:

State Resources
- ☐ Voc Rehab
- ☐ Division of Aging
- ☐ DFCS
- ☐ Family Support Provider
- ☐ CMS
- ☐ Who to contact for PL changes (Regional Office)

Advocacy Groups / Other Resources
- ☐ Unlock the Waiting List
- ☐ Family Connections
- ☐ Parent to Parent
- ☐ Emory Autism Center
- ☐ SOURCE

- ☐ Local Community contacts
- ☐ Respite Provider
- ☐ Division of Aging
- ☐ Support Coordination
- ☐ United Way
- ☐ Marcus Institute
- ☐ Other

VII. Other Recommendations

Signature of Staff Completing the Screening	Date of Screening